Testimony Summary - March 13, 2007

Leslie D. Hirsch, President & CEO of Touro Infirmary, New Orleans, Louisiana

As President and CEO of Touro Infirmary, a private, not-for-profit and faith-based major teaching hospital located in New Orleans' Garden District, I have an intimate understanding of the healthcare concerns and needs of our region. I am here today to speak about a number of post-Katrina problems that continue to plague Touro and other hospitals in New Orleans, as well as the delivery of healthcare in our community generally. I will also propose several recommendations that we believe would facilitate our recovery.

We are grateful for the continued interest and efforts of Congress, the President, Secretary Leavitt and the many others who have visited the area frequently.

Post-Katrina there are a number of significant issues that have had a negative impact on the operation of hospitals in the New Orleans metro area and the healthcare delivery system generally. These include, but are not limited to:

- The unprecedented amount of uncompensated care provided by area hospitals;
- The increase in percentage of uninsured population and lack of an effective system of healthcare for this population causing an excessive strain on, and inappropriate use of, emergency services;
- The steep rise in the cost of labor, excessive reliance on contract labor and shortage of an adequate supply of trained healthcare personnel;
- The significant increase in cost and subsidization by those hospitals that have expanded their support of graduate medical education;
- The dramatic rise in the cost of property and casualty insurance;
- The lack of adequate primary, specialty and preventive health care services; and
- The lack of an adequate number of in-patient psychiatric beds and the resulting impact on area hospitals' emergency services.

Recommendations:

1. Implement healthcare redesign
2. Approve Cost-Based Reimbursement
3. Approve a Medicare Wage Index Adjustment
4. Increase Funding for Uncompensated Care:
5. Approve Waivers for Graduate Medical Education
6. Increase Access to Physical Rehabilitation Services
7. Approve Additional Funding To Increase Health Manpower
8. Deploy Federal Resources to Help Relieve Pressure on Area Emergency Rooms
9. Approve Additional Funding to Offset Cost Increases in Insurance:

Thank you again for the opportunity to be here today. I welcome any questions that you may have.

Testimony of Leslie D. Hirsch
President & CEO
Touro Infirmary, New Orleans, LA
Before the
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives

March 13, 2007

Mr. Chairman and members of the subcommittee, thank you for inviting me to testify today and for continuing to keep New Orleans and post-Katrina healthcare a national priority. As President and CEO of Touro Infirmary, a private, not-for-profit and faith-based major teaching hospital located in New Orleans' Garden District, I have an intimate understanding of the healthcare concerns and needs of our region. I am here today to speak about a number of post-Katrina problems that continue to plague Touro and other hospitals in New Orleans, as well as the delivery of healthcare in our community generally. I will also propose several recommendations that we believe would facilitate our recovery.

Let me begin by saying thank you for your support of New Orleans in the eighteen months since Katrina devastated our city. We are grateful for the continued interest and efforts of Congress, the President, Secretary Leavitt and the many others who have visited the area frequently.

While appreciating the assistance that we have received to date, we are concerned that many parts of New Orleans remain devastated. It's very difficult to accept the fact that

these areas are still devastated more than a year-and-a-half later, especially considering that this condition exists in the United States of America. We acknowledge that this situation involves all levels of government.

Katrina devastated healthcare delivery in New Orleans and the surrounding areas. Thousands of dedicated healthcare workers---physicians, nurses, administrators, other allied health professionals, support staff, and community volunteers--have worked tirelessly to rebuild healthcare post Katrina. Although a valiant effort is being made, we are fighting a losing battle every day. The delivery of healthcare in New Orleans is a much greater challenge today than it was in the first few months following the storm. Conditions have worsened and continue to do so as more individuals return to New Orleans and the demands on the healthcare system increase. Healthcare is a core requirement of the city's recovery and the current system is in jeopardy. Additional Federal support is desperately needed to help stabilize and improve the situation.

Since its founding 154 years ago, Touro Infirmary has endured and recovered from more than its share of obstacles, but it wasn't until Hurricane Katrina struck that Touro would confront the greatest challenge of all. For only the second time in its history, Touro Infirmary closed. On September 1, 2005 we were forced to evacuate 238 patients, as well as hundreds of staff and family members. We were very proud to be the first hospital to re-open in the city just twenty-seven days later and to play a critical role in New Orleans' recovery along with the other hospitals in Orleans and Jefferson Parishes that have also shouldered a great burden-- financial and otherwise.

Touro's re-opening and the important role it has played as a safety-net provider has been accomplished at a huge financial cost. Since the storm, Touro has operated at a substantial deficit. Due to the current situation, the Touro Governing Board recently approved a deficit operating budget for 2007. We continue to erode our cash reserves at a rapid pace, and endure the impact of resulting changes in our bond and credit ratings. We are not alone. There have been a number of recent stories in the news media stating that hospitals in the New Orleans area are bleeding red ink post Katrina.

Pre-Katrina the New Orleans metro area was estimated to have between 4,000 and 5,000 hospital beds. As reported most recently in the Times Picayune (March 11, 2007) there are currently about 2000 beds in operation. The situation in Orleans Parish is particularly challenging, as the number of adult acute care beds in operation remains dangerously low at about 500 to serve a population estimated at 200,000. In addition to Touro Infirmary which is staffed for 280 beds, there are only two other full-service adult acute care hospitals in operation. These include Tulane and the recently re-opened University Hospital that is a part of the state's Charity System. Touro, Tulane and University are also the only adult hospitals in Orleans Parish operating emergency services. Touro continues to be the busiest hospital in Orleans Parish.

Post-Katrina there are a number of significant issues that have had a negative impact on the operation of hospitals in the New Orleans metro area and the healthcare delivery system generally. These include, but are not limited to:

- The unprecedented amount of uncompensated care provided by area hospitals;
- The increase in percentage of uninsured population and lack of an effective system of healthcare for this population causing an excessive strain on, and inappropriate use of, emergency services;
- The steep rise in the cost of labor, excessive reliance on contract labor and shortage of an adequate supply of trained healthcare personnel;
- The significant increase in cost and subsidization by those hospitals that have expanded their support of graduate medical education;
- The dramatic rise in the cost of property and casualty insurance;
- The lack of adequate primary care, specialty care and preventive health care services; and
- The lack of an adequate number of in-patient psychiatric beds and the resulting impact on area hospitals' emergency services.

Uncompensated Care and the Uninsured

Nationally, the uninsured population has been reported at about 16%. Even prior to Katrina the percentage of the uninsured population in Louisiana and New Orleans significantly exceeded the national rate. Post Katrina this situation has worsened. Recent reports estimate the rate of uninsured in New Orleans ranges from 20.4% to 26.1% (LPHI). Louisiana continues to have one of the highest percentages of uninsured as well as those living below the poverty level. Not surprisingly, various published reports have identified Louisiana as ranking 49th or 50th with respect to the health status of its population. The lack of an adequate supply of primary and specialty

care physicians and a coordinated system of care for the uninsured causes patients to seek treatment for minor illnesses in emergency rooms across the region. This has caused severe backlogs, overcrowding and excessive delays in treatment and significant financial losses for hospitals.

The sharp increase in uncompensated care is a financial strain on hospitals throughout the region. Since Hurricane Katrina devastated the New Orleans hospital system, an unprecedented amount of uncompensated care has been provided by the already challenged private and nonprofit healthcare providers in the region. Last year for the first time in Louisiana a charity care pool of $120 million was established to help fund the cost of uncompensated care at community hospitals. While appreciating the creation of this pool it is a partial solution and only covers about 40% of the cost of treating the uninsured.

For example, Touro's charges for uncompensated care have skyrocketed from $17 million pre-Katrina to $41 million in 2006, an increase of 141%. Our Emergency Department has seen a dramatic increase in volume post-Katrina from approximately 20,000 visits per year to 30,000. Uninsured patients originating in Touro's Emergency Department are responsible for about 90% of Touro's uncompensated care. This is an unsustainable position for Touro. Other area hospitals are experiencing similar difficulties. Hospitals cannot survive without being compensated for the care they provide. It is an **unfunded mandate** that must be addressed.

Cost of Labor and Contract Labor

Prior to Katrina, Louisiana was designated by the federal government as a health manpower shortage area. That designation continues today. However, the post-Katrina labor challenges, particularly in the New Orleans metro area has worsened significantly. Our area has experienced large increases in the cost of labor, as well as shortages of critical health care personnel needed to fill both direct patient care and support positions. It is noteworthy that the labor shortage is not just limited to healthcare. For example, fast food restaurants in New Orleans have offered sign on bonuses as high as $6,000 as a way of luring new recruits from a limited labor pool.

The national nursing shortage is exacerbated in post-Katrina New Orleans where hospitals face a highly competitive healthcare market in terms of the availability, recruitment and retention of qualified staff. Post-Katrina, salary rates have risen significantly. The use of contract or agency labor, particularly with respect to registered nurses, is a large component of the labor shortage issue and hospitals' reliance on this type of staffing has grown exponentially. For Touro and others, this issue is of equal magnitude to that of uncompensated care in terms of having a negative impact on the financial viability of our hospitals.

Moderate use of temporary staffing services can be helpful in certain situations. However, we believe that the disproportionate dependence on post-Katrina contract labor has significantly increased hospital staffing costs. At the same time, hospitals are

unable to commensurately raise their rates to commercial or governmental third party payers to offset these increased costs. At Touro, the total labor cost for each man-hour increased 20.4% from 2005 to 2006 (see Table 1). This increase was driven largely by the cost of temporary contract labor which increased nearly 500% from 2005 to 2006. Indeed, the annual cost of a full-time equivalent registered nurse provided via a temporary staffing agency is approximately $50,000 higher than the cost of salary and benefits for an R.N. employed by the hospital. In 2006, 17% of Touro's labor cost was for contract labor and amounted to $13.9 million (see Table 2).

Cost is only one side of the issue. There are a number of other issues associated with the excessive use of contract labor, not the least of which is continuity of patient care.

Graduate Medical Education (GME)

In the aftermath of Katrina, Touro and other local hospitals expanded their residency training programs to absorb as many resident physicians as possible, thereby supporting and protecting the future of graduate medical education in New Orleans. Touro increased its program from eighteen to fifty-two.

Our commitment to help secure the future of graduate medical education has been very costly because of a federal rule that does not permit full reimbursement in the first year. Instead costs must be averaged over a three-year period. In effect, hospitals expanding their GME programs are financially penalized during this initial period and must absorb these added costs. This rule clearly did not envision the hardship created by Katrina.

While it is our understanding that CMS attempted to address this concern through a partial waiver to allow full costs for an initial period that ended on June 30, 2006, it denied a waiver of the three-year averaging rule beyond that date. As a result, hospitals that provided the needed increase in support to help protect the future of New Orleans' GME will be penalized financially for the next three years. At Touro, the incremental cost of increasing the number of residents from eighteen to fifty-two during the first three years is $9 million. Of this amount, $4.5 million is related to the three-year averaging requirement. Touro's subsidization of GME is a material part of our budget deficit this year and as a result we must re-evaluate our position on this issue.

Property and Casualty Insurance

Property and casualty insurance costs have skyrocketed in the aftermath of Katrina. Touro's cost has increased by 374% from under $500,000 per year to $2.2 million (see Table 3). At the same time our coverage has declined.

Additionally, we have taken a number of steps to harden our facilities to help Touro better prepare to withstand future disaster situations, thus increasing its reliability for serving the community in a time of need and reducing its exposure to significant financial losses and claims. These steps included the installation of a water-well and an upgraded emergency generator loop. We are appreciative of FEMA's approval of the water-well, but are very disappointed in their denial of the generator loop project even though we were led to believe that this project would meet FEMA's guidelines. We

could not wait for FEMA to act and have completed this $4 million project. We will appeal to FEMA to reconsider its decision and are hopeful for a successful outcome.

Recommendations

1. **Implement healthcare redesign**: The impasse that exists between the federal government and the State of Louisiana to develop an acceptable and workable model initiative to reform healthcare in Louisiana, and especially in the New Orleans Region One area, must be resolved immediately. The impasse with respect to this issue that also exists among various parties within the State of Louisiana must also be immediately resolved. It is critical that healthcare re-design must focus on drastically reducing the percentage of the uninsured population, strongly support primary and specialty care, as well as preventive services, provide participants with the freedom of choice to obtain healthcare services, and assure that funding "follows the patient" and is not institution specific. These steps would result in a drastic reduction in the inappropriate use of emergency rooms for primary care and an overall improvement in the health of the population ultimately at a lower cost. The goal should be to improve health status in the state by 50% within ten years. While healthcare redesign is critically needed, in the interim there are other actions that can be taken to help the situation now.
2. **Approve Cost-Based Reimbursement**: Implementing a cost-based reimbursement system for hospitals in hurricane affected parishes and

particularly for hospitals located in the hardest hit area, Region One, for the next three years will help to address many of the issues identified. It can be implemented immediately in the interim until healthcare redesign is finalized. Treat our hospitals as "critical access hospitals" similar to the treatment given to hospitals located in rural areas.

3. **Approve a Medicare Wage Index Adjustment**: The Medicare Wage Index adjustment will not reflect the unusual market conditions in New Orleans until October 2009. Although we appreciate Secretary Leavitt's recent announcement of $71.6 million dedicated to help offset the labor cost increases impacting hospitals in Louisiana, we do not believe that it will adequately cover the significant labor cost increases in New Orleans. Analyze the gap between this amount and the true need and make an adjustment immediately.
4. **Increase Funding for Uncompensated Care**: More federal assistance in treating the uninsured is needed. Consider providing special grants for those hospitals most affected by this issue.
5. **Approve Waivers for Graduate Medical Education**: The presence of graduate medical education and a strong health sciences infrastructure is critical to the long-term recovery of New Orleans. It is also an important source of new physicians who will replace some of those who have left the region post Katrina. Approve a waiver of the three-year averaging rule so that hospitals that have stepped up in support of graduate medical education during this time of need will not suffer adverse financial consequences. Approve additional family practice

residency training slots to increase the supply of primary care physicians in New Orleans, and remove or waive administrative barriers to adding new programs.

6. **Increase Access to Physical Rehabilitation Services**: Physical rehabilitation services, particularly for brain injury patients, are in short supply. At no cost to Medicare, rehabilitation hospitals could be permitted to change status to become rehabilitation units of general hospitals without the current one-year reduced payment penalty. To do so will add significant efficiencies, thereby permitting much better access to these vital services.
7. **Approve Additional Funding To Increase Health Manpower**: Approve additional funding or revise existing federal programs to provide incentives for physicians, nurses and other key health care professionals to relocate to New Orleans for a three year period in exchange for grant support to pay for tuition. Designate New Orleans as an *underserved area* for this purpose. Provide hospitals with direct funding to provide similar incentives such as: physician practice guarantees, loan forgiveness, recruitment and retention bonuses, and housing subsidies. The $15 million grant for the New Orleans area recently announced by Secretary Leavitt, while appreciated, is flawed because it restricts hospitals from directly participating and must be re-evaluated.
8. **Deploy Federal Resources to Help Relieve Pressure on Area Emergency Rooms**: Post Katrina DMAT's (disaster medical assistance teams) were deployed to New Orleans. These teams provided some useful purpose in the immediate aftermath of the storm but left before the population returned. In view of the heavy demands now being placed on emergency rooms (ER) in the New

Orleans metro area, particularly by uninsured patients using ER's for primary care DMAT's should be deployed. This would help to immediately alleviate the excessive delays in treatment and overcrowding that currently exists.

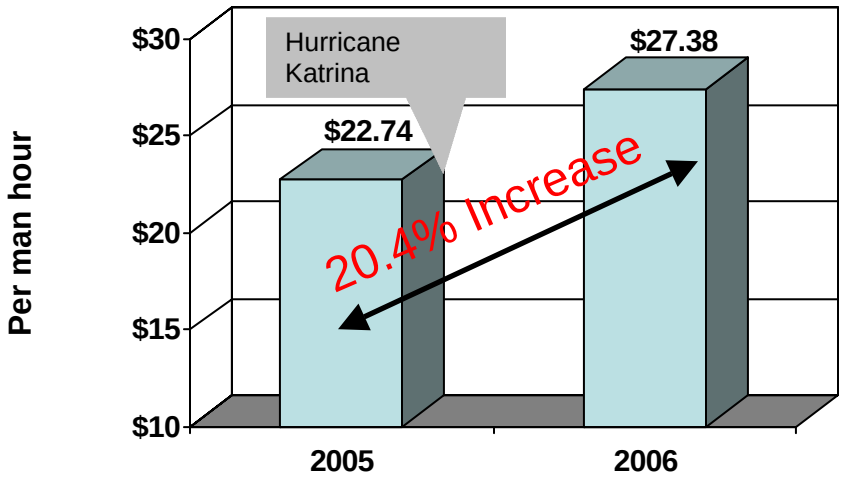
9. **Approve Additional Funding to Offset Cost Increases in Insurance**: Property and casualty insurance costs in New Orleans have skyrocketed post-Katrina. Provide funding for the next three years through a special adjustment in the rate paid to New Orleans hospitals by Medicare.

Thank you again for the opportunity to be here today. I welcome any questions that you may have.

Appendix:

Table 1

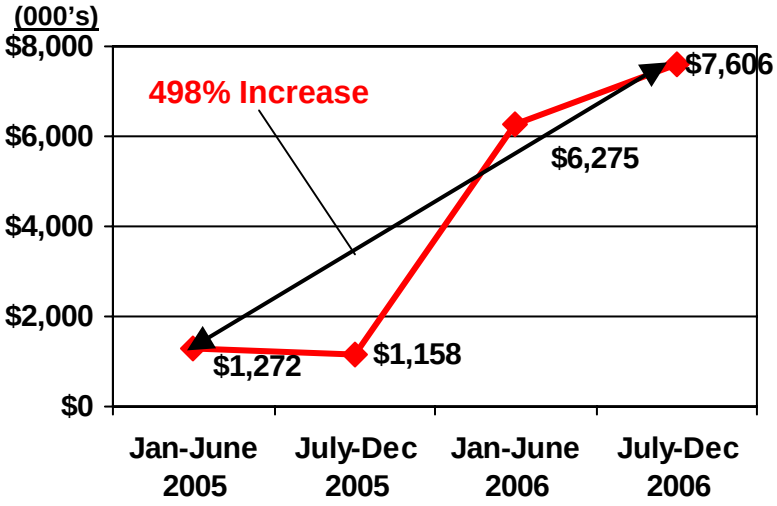
Labor Cost per Man Hour Paid
(Touro Infirmary including Contract Labor)



SOURCE: Touro Financial Statements

Table 2

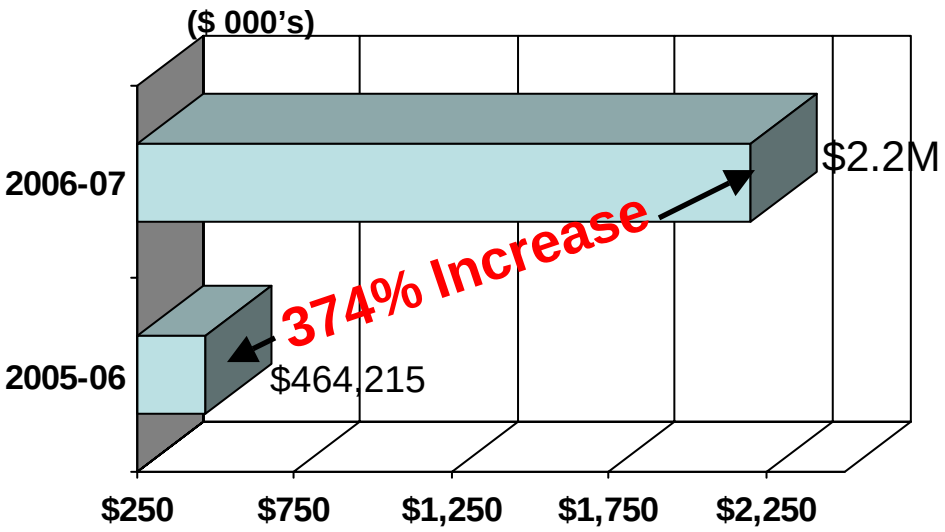
Contract Dollars



SOURCE: Touro Financial Statements

Table 3

Property and Casualty Insurance Premiums



SOURCE: Hartwig Moss Insurance

News Articles

Grant partially repays Touro
Hospital helped care for uninsured patients
Wednesday, February 14, 2007
By Kate Moran
The Times-Picayune

Touro Infirmary, the Uptown hospital that shared the burden of caring for uninsured patients since Charity Hospital closed, announced Tuesday that it will receive a $4 million reimbursement grant from the state.

Leslie Hirsch, Touro's president and chief executive, said the hospital spent $41 million caring for uninsured patients last year, $22 million of that in the first half of the year. The hospital has taken a loss on those services.

The state grant helps compensate the hospital for care administered to uninsured patients in the first half of last year. Touro expects to receive a second grant in May for care given in the second half of the year.

"This is far short of what our true costs are, but the good news is at least we are getting some funding," Hirsch said at a morning news conference.

In July, the Legislature earmarked $120 million to compensate nonprofit and community hospitals for treating indigent patients who used to seek care through the charity system. That money started trickling down to the hospitals only recently because the state took months to develop a formula for how much money each institution would receive.

In late January, the state announced it would disburse $8.7 million to West Jefferson Medical Center and $3.6 million to East Jefferson General Hospital for treating uninsured patients. Those suburban hospitals, along with Touro and Ochsner Health System, have become the de facto safety net since Charity closed.

Hirsch expressed gratitude to the state for the money, but he said legislators must come up with a plan for reimbursing local hospitals over the next several years as the state considers a permanent redesign of its health-care system.

"As we anticipate the next legislative session, it is important that funding is not only continued but increased," Hirsch said.

Uncompensated care is 'killing' N.O. hospitals
By Jaime Guillet Staff Writer

New Orleans CityBusiness

2007-02-13 1:43 PM CST

NEW ORLEANS — New Orleans-area hospital officials continue to call Code Blue to stop the bleeding from uninsured patient care charges. But relief remains elusive.

Patients at local hospitals have arrived in poorer health and with less insurance post-Katrina. Health care facilities are hemorrhaging millions in uninsured care costs plus higher labor and health care expenses.

With many Orleans Parish hospitals closing after the storm, including uninsured care provider Charity Hospital, Jefferson Parish hospitals and Touro Infirmary in New Orleans are treating most uninsured patients.

While awaiting federal and state compensation for treating uninsured patients hospital officials face mounting budget shortfalls.

"In Orleans Parish, we have the busiest inpatient census on any given day and we're shouldering the burden of uncompensated care," said Leslie Hirsch, Touro president and CEO. "I don't think people realize the magnitude of rebuilding health care in New Orleans."

The number of uninsured residents in the New Orleans area tops 20 percent compared with the national average of less than 15 percent, Hirsch said, a problem that predates Katrina. A 2004 state Department of Health and Hospitals study found Louisiana has one of the highest percentages of uninsured citizens in the nation.

The most recent DHH survey of the approximately 191,000 residents living in Orleans Parish post-Katrina, conducted between June and October, found the percentage of uninsured hadn't budged despite a much smaller population.

Hirsch suspects the uninsured rate is even higher than measurements indicate.

"I have a hard time believing (the uncompensated care population is 20 percent) just based on what is going on here," Hirsch said. "Our charges for uncompensated care have gone through the roof."

Uninsured care costs for Touro, as well as East Jefferson General Hospital, Ochsner Health System and West Jefferson Medical Center, are all in excess of $20 million:

— Touro's uncompensated care costs increased 141 percent from $17 million in 2005 to $41 million in 2006.

— West Jeff's uninsured costs increased 6 percent from $31 million in 2005 to $33 million in 2006.

— East Jeff's uninsured costs decreased 7 percent in 2006 from $27 million in 2005 to $25 million but remain triple pre-Katrina costs, said EJGH President and CEO Mark Peters. The pre-Katrina figure was not available at press time.

— Ochsner's costs increased 67 percent from about $12 million in 2005 to an estimated $20 million in 2006.

Poor patient health

Patients are also coming in much sicker.

"We're seeing more (patients) but it's not the number that's disturbing. It's how sick they are when they get here," said Dr. Alfred Abaunza, West Jeff chief medical officer.

Many people no longer have established health care outlets where they receive regular medical attention, monitor diabetes or high blood pressure, receive prescriptions so many residents do without, Abaunza said.

"They're sicker now (and) it may take a day longer to treat them," Abaunza said.

Physicians believe residents are much sicker, said Dr. Carl "Chip" Lavie, Ochsner Health System medical director of cardiac rehabilitation.

"We have noticed as a group — many of us talked about it — over the last year and a half patients are more stressed out, eating worse, exercising less, putting off medical examinations, putting off their maintenance (and) stopped refilling their medication because they don't care," said Lavie. "Unless they're acutely sick, they've been neglecting their health visits."

Some financial help finally arrived more than 17 months after Katrina. On Feb. 2, West Jeff and East Jeff received a portion of the $120 million — $8.6 million and $3.6 million, respectively — appropriated by the Legislature in 2006 to relieve uncompensated care costs. Ochsner and Touro expect to receive funding any day now.

"Our goal in making the payments to the hospitals was to have all payments processed and mailed before mid-Feb," said DHH spokesman, Robert Johannessen. "This required us to get the necessary data from all of the eligible hospitals, and then review it and calculate the payments. Because East and West Jefferson submitted data to us before the Jan. 12 deadline, and because we were able to complete the necessary reviews first for those hospitals first, they were paid first."

All four institutions expect to receive their second and final portions of the $120 million in May, with East Jeff and West Jeff receiving $900,000 and $2.1 million, respectively. But the payoffs fall far short of covering costs of uncompensated care, which affects bond ratings and eats at budgets needed to pay for cutting-edge technologies.

The funding is merely a drop in the uninsured cost bucket, administrators say.

A. Gary Muller, West Jeff president and CEO, projects uncompensated care charges in 2007 will be $36 million but there is a proposal to the Legislature for 100 percent coverage of indigent care costs.

"(The payments) are way too slow," Muller said. "They've finally come through but it's way too little, too late."•

New Orleans City Business, Tragic social problems threaten N.O. economic viability
By Publisher Mark Singletary COMMENTARY

2007-02-15 6:00 PM CST

NEW ORLEANS — What happens if we lose our teens for good??

In last week's CityBusiness, two front page stories dealt with manifestations of poverty — uninsured medical costs and teenage criminals. Neither issue is pleasant dinner table chatter. Both are important for our future.

In our crime story, Reporter Richard A. Webster interviewed several teenagers for their take on New Orleans street crime. From all indications, these are decent kids. Most of them talked about responsibilities and an obligation to their families. But there was an underlying sense of desperation in all their quotes.

I thought over and over as I read the piece that these children weren't spending their days wondering whether to become an engineer, an astronaut or a welder. These children spend most of their time trying to figure out how to stay alive.

Too many of them, nearly all in fact, told our reporter that dying wasn't a big deal. These children are way too comfortable with death and dead people.

It's not surprising the important issues in their lives don't match up with those of a traditional middle class family. They are too busy wondering and worrying about their next meal or where they might sleep tonight to be concerned about this week's spelling test or algebra quiz. These children live in a world where they and their friends worry about existence, not so much about quality of life.

They aren't concerned or embarrassed by their lack of education. They are completely unaware, at this point in their lives, of the benefits of a quality education. The quotes in the news story were sad.

"I have friends that don't have no life," 17-year-old Amina Woods said. "They don't have no food; they don't have no water." The last thing on her mind was proper speech. She had a story to tell and did the best job she could. She made her point remarkably well.

Unfortunately, they aren't concerned about their future much beyond tomorrow. They didn't give any indication they spend a lot of time thinking about economic opportunity in traditional terms, either.

As 18-year-old Milton Davis said, most of the kids he knows who deal drugs think that is the only way to make a decent living in New Orleans. Those are not middle class values. Those thoughts come from desperate poverty.

Moral and economic poverty placed these children in a world as far away from middle class values and aspirations as the real middle class is from Prince Charles and Camilla.

The other hard news story on last week's front page was about the tremendous economic burden on our local hospitals caused by indigent care.

In the past two years, four local hospitals — Touro, East Jefferson General Hospital, West Jefferson Medical Center and Ochsner Health System — spent more than $174 million treating uninsured (indigent) patients. To date they have been reimbursed for about $12 million in losses.

I refer you to the teenagers above and offer that these kids don't likely have health insurance nor a primary care physician. When these children and their families get sick, they go to the emergency room for medical treatment. The hospitals cannot refuse to treat them based on their ability to pay. That ability is usually determined during the intake interview.

Whether paid for or not, the hospitals legally must provide excellent health care.

We have a dilemma.

Hospitals need to be paid for doing the job. If hospital bills aren't paid, how can administrators afford to hire doctors, nurses and orderlies, who all expect to be paid for doing their job, too?

These tragic circumstances play out in our city and the region every day. The dangerous and unknown conditions that may seem normal to us now are having an impact on the working middle class that we need to be normal and prosperous.

We are on the brink of so many good things happening in our community. It appears The Road Home may soon be paved with something other than hollow promises and families may have a reason to come home and rebuild.

Let's take the opportunity to address these social problems before they become insurmountable economic inhibitors.

Then we all lose.

Hospitals and Health Networks - American Hospital Association magazine
Friday, March 9, 2007

New Orleans revisited

Louisiana's Second Chance
By Howard Larkin

Hurricane Katrina washed away most of the health care safety net in New Orleans, battered hospitals and drove off many doctors, nurses and skilled caregivers. It also created anopportunity to replace the region's antiquated health care system.

If ever there was a state health care system crying out for reform, it was Louisiana's, pre-Katrina. Costs were high but outcomes were among the poorest in the nation.

Per capita health care consumption was at or near the top in nearly every category—from inpatient care to prescription drugs. Yet the state ranked 49th or 50th in overall health status for 15 years in United Health Foundation's annual State Health Rankings.

Medicare costs per beneficiary passed $8,000 in 2001, the highest in the nation. But quality was lowest among all 50 states, as measured by Centers for Medicare & Medicaid Services benchmarks. In 2005, Medicare costs in the last year of life averaged nearly $60,000 in Louisiana compared with about $36,000 nationally.

More than one in five, or about 817,000, Louisiana residents were uninsured. And 90 percent-plus of health care services to these mostly low-income residents were provided through a state-run network of 10 public hospitals and about 350 clinics. Also known as charity hospitals, this relic from the populist Huey Long era served most Medicaid recipients as well, creating an explicitly two-tiered delivery system. Not surprisingly, chronic underfunding of the state network produced long waits for service in antiquated facilities. Patients with Medicare and private insurance, meanwhile, mostly used private hospitals, with far lower occupancy rates.

"There was excess capacity in the private market, but on the public side we had facilities that weren't in good shape and had more demand than they could handle," says Frederick P. Cerise, M.D., secretary of the Louisiana Department of Health and Hospitals.

Financing reinforced the problem. While the charity system consumed a disproportionate share of the federal hospital funds and a good chunk of the Medicaid budget, it also insulated private hospitals from the burden of uncompensated care, notes Donald R. Smithburg, executive vice president and CEO of the Louisiana State University Health Care Services Division, which runs the state hospital network. "The private hospitals had a pretty good thing going," he says.

The situation was far from ideal—and everyone knew it. But the inertia of long-established institutions and practices, financial constraints, and the ingrained habits and expectations of patient populations locked the status quo in place.

"There are so many entrenched behaviors that it is hard to change," says Patrick Quinlan, M.D., CEO of the Ochsner Clinic, which now operates five acute care hospitals, a surgical hospital, a subacute facility and 25 health centers in southern Louisiana. "A catastrophe makes it easier."

Catastrophe struck on Aug. 29, 2005, when Hurricane Katrina washed away most of the infrastructure of New Orleans' health care safety net and drove off much of the population it served—along with many doctors, nurses and other skilled caregivers. In the aftermath, state leaders saw a unique opportunity to reinvent health care delivery. Yet even as disparate parties come together, they find that nothing is easy.

Six months after the storm, Charity Hospital and University Hospital, the two state facilities in town that had operated about 570 beds, were among the six in Orleans Parish that remained closed. Only three hospitals had opened, and these only partially, resulting in an 80 percent reduction in staffed beds. With both its operations and finances disrupted, LSU laid off 90 percent of its New Orleans health system staff by the end of 2005. It would be November 2006, nearly 14 months after the storm, before LSU reopened 84 beds at University Hospital.

However, LSU permanently shuttered Charity Hospital, a highly controversial decision given the dire need for safety-net services. The closure also came amid wildly divergent projections about the cost of restoring the 1930s vintage facility. The Federal Emergency Management Agency estimated that storm damage repairs would come to $23.9 million—less than 10 percent of LSU's $257 million estimate of what it would take to repair and update the hospital. Instead, LSU decided to build a single new facility to replace both Charity and University Hospital, which dates from 1972. In December, the system won a $320 million commitment from the Louisiana Recovery Authority to begin that project, which will not be completed for years.

Sharing the pain

The impact on private hospitals is severe and ongoing. Touro Infirmary, which staffed 365 beds before the storm and was the first hospital serving adults to reopen in Orleans Parish, lost more than $5 million on operations in the first 10 months of 2006, says President and CEO Les Hirsch. Emergency department visits will top 30,000 this year, up from about 20,000 annually before the storm, and many of these patients are uninsured. "The incremental increase in uncompensated care since '05 exceeds our total operating loss," Hirsch says.

Likewise, Tulane University Hospital saw uncompensated care jump as high as 40 percent of patients after it reopened 63 beds in February 2006, says Alan M. Miller, M.D., associate senior vice president for health sciences at Tulane University. Since University reopened, about 12 percent of inpatients at Tulane are uninsured, though rates in the emergency department are much higher.

Ochsner made a major contribution to shore up the sagging public safety net by leasing space in one hospital to LSU to re-establish trauma services. With the trauma unit moving to the reopened University Hospital, Ochsner is restoring full services at the smaller facility, as well as at three other community hospitals it picked up last year from Tenet Healthcare Corp. The clinic also opened its major hospital in Jefferson Parish to indigent patients. “We’re less than a mile from the [Orleans] parish line. I can see downtown from my office,” Quinlan says.

Recognizing the burden that private hospitals were shouldering, the Louisiana state legislature in early 2006 diverted funds formerly dedicated to the state charity system to create a $120 million uncompensated care fund. Medicaid rates also were raised about 4 percent.

The legislature also moved to correct the structural flaws of the state’s health care system by creating the Louisiana Health Care Redesign Collaborative. The group brought together representatives from government, hospitals, patient advocacy groups and business to come up with a better way.

Its explicit charge: “to develop, and oversee the implementation of a practical blueprint for an evidence-based, quality-driven health care system for Louisiana.”

A concept for rebuilding

Despite a history of divergent interests, wrangling and even frank distrust among coalition members—divisions often highlighted in press coverage during the nine months it took to develop a preliminary reform plan—the group functions smoothly, members say. “You might think a group this diverse would have difficulty finding common ground, but they were very polite, engaged and outcome-oriented,” Quinlan says. In October, the coalition presented a concept paper that outlines its consensus plan for rebuilding the state and city health systems.

Broadly, the paper calls for shifting government financing away from a dedicated hospital and clinic system in favor of expanding insurance coverage. Funding would support expanded Medicaid coverage and subsidies for private insurance for low-income workers. In theory, this would improve access and efficiency by giving patients a choice of providers.

The plan also calls for providers to be paid at rates that cover the cost of services. “The idea is that the money will follow the patient instead of the institution,” says John Matessino, president and CEO of the Louisiana Hospital Association. “It creates a level playing field for everyone.”

Of course, extending coverage to thousands of new individuals will be costly. But the plan assumes a major portion of that funding will come through increased efficiency. Each enrollee would have a “medical home,” which is a clinic or system responsible for ensuring patients receive primary care and for coordinating specialty and inpatient care.

Specialized medical homes and treatment networks would be established to meet the complex needs of disabled, severely or chronically ill and end-of-life patients.

The idea is that preventing acute illness through effective primary care, basing services on evidence-based protocols and steering terminal patients into coordinated hospice and other appropriate nonhospital settings will both improve population health and ultimately lower overall costs. “There’s likely to be a spike in the short term as newly insured patients seek more care, but it should decline as time goes on,” says Cerise, the state health secretary.

Information technology is another key to improved efficiency. Medical homes and specialty care networks are to be coordinated using interoperable medical record systems. This is supposed to prevent duplication of services and delivery of unnecessary or unproven services, and to ensure that patients receive all the care they need when they need it to manage chronic and acute conditions. Physicians, hospitals and other providers will be required to install interoperable record systems to participate.

A statewide quality forum will be established to monitor outcomes and set standards for evidence-based care. Patients will purchase coverage through an insurance connector, making competitive health plans offered by all insurers available to everyone. “It really provides for much more comprehensive access to health care for the citizens of the state,” Tulane’s Miller says. “Hopefully, it would lead to a lot more of the care being given at the front end in terms of preventive and primary care rather than most care happening after serious illnesses have occurred.”

Ochsner’s Quinlan puts it more bluntly: “This is chapter one in the book of population-based health care. It’s called ‘modern medicine.’ As an integrated hospital system and multispecialty clinic, we’ve been practicing under this model for years.”

Obstacles to reform

But as perfectly rational and equitable as the cooperatives’ plan may be, it must make its way in an imperfect world governed by uncertain financial resources and political processes. Among the challenges New Orleans must address:

• Uncertain demographics: Much of Orleans Parish remains uninhabitable and its population is unlikely to return to its near half-million level, particularly if the area’s levee systems are not upgraded. However, the population in the surrounding parishes is expanding rapidly, and by some accounts is already near pre-storm levels. Also, the wealth of construction jobs has attracted Hispanic and other immigrant groups in numbers never before seen in the area. The ultimate number, location and economic circumstances of this rapidly changing population are major unknowns complicating everything from facility location planning to the magnitude of potential insurance subsidies.

• Health care workforce shortage: Hospital closures, loss of housing and failure of basic services including public schools and police protection forced thousands of nurses, doctors and other health professionals out of the area. With many now established in other communities, getting them back is a challenge. Cerise estimates that there are currently about 450 primary care physicians in the New Orleans area, down from about 1,500 before the storm. Whether existing private physicians have the skill and willingness to implement the managed care-style service coordination required by the medical home model is another open question. Mental health practitioners are in particularly short supply even as the city faces an epidemic of stress-related disabilities. Lack of nursing staff prevents hospitals across the area from opening or expanding beds. Severe nursing shortages have driven annual wage and benefit costs over $120,000 in some cases, partly because hospitals must rely on traveling agency nurses to fill the gaps. Overall, wages are up 22 percent at Touro, Hirsch says. Even unskilled labor is at a premium, with even fast-food outlets raising wages from about $7 per hour to $12, according to the U.S. Government Accountability Office. The state has requested an emergency increase in the Medicare wage index to offset the costs.

• Patient behavior: After decades of relying on emergency rooms for care and with little experience with preventive care, patients in Louisiana will have to learn how to interact with a coordinated, primary care-focused system. This will require a major public education effort. And with little managed care penetration in the market, consumers will be challenged to accept the limits such models are likely to impose.

• Information technology: Interoperable patient records are at the heart of the system's ability to coordinate care and generate the efficiencies needed to sustain it financially. Hundreds of volunteers from across the country have contributed equipment and expertise to set up electronic systems in clinics opened since the storm, says Scott Wallace, president of the National Alliance of Health Information Technology. But first, the medical home system and specialty networks must be set up, and protocols for delivering care and sharing information established. "Interoperability is three or four steps down the road," he says. Matessino of the state hospital association has called for a delay in requiring interoperable systems to avoid a setback in rebuilding.

• Funding: Covering an additional half-million or so Louisiana residents will cost more money even if the system can reach optimal efficiency—LSU's Smithburg estimates a half-billion dollars beyond current levels. And some of the money currently available through Medicare, Medicaid and DSH will have to be shifted to accommodate the medical home model. The state is working with the federal government on waivers that would allow DSH funds to finance insurance subsidies, allow Medicare dollars to fund capitated coordinated care programs for Medicare-Medicaid dual eligibles, and to expand Medicaid eligibility. But the fate of these waivers was uncertain at press time. Even if the fedes agree, the state may not be able to afford its share. As of November 2006, Cerise's office projected a shortfall reaching $66 million by 2012, even assuming full funding.

These challenges create huge risk. Jumping into an underfund-ed public insurance program could permanently saddle private hospitals with huge uncompensated care problems. “If you swap the [hospital-based] safety net for an insurance product that is not appropriately funded so that it is usable, the patients are stressed, the public facilities are stressed and the private facilities are stressed,” Cerise warns. “We won’t step into this lightly. We won’t do it if we don’t get the funds.”

Matessino ex-presses similar reservations. “Am I concerned about funding? You bet,” he says. Failure to maintain funding has sunk many a state universal coverage initiative, with TennCare a recent example.

Nonetheless, New Orleans’ health care community is proceeding full bore and establishing the networks required to make the coordinated system work. Ochsner sees its efforts to recruit physicians to community hospitals as a way of extending the clinic’s multidisciplinary approach throughout the region. Tulane sees connections with re-established community clinics and new training programs in community hospitals and the proposed LSU and VA facilities as a way to better integrate care and teaching missions. LSU sees its planned replacement hospitals as a way to extend its expertise in delivering clinic-based comprehensive services to a broader market. “With a state-of-the-art inpatient facility, we can attract Medicare and privately insured patients,” Smithburg says.

“Whether enough funding comes through to fully realize the new system or not, hospitals have a civic duty to move toward a new, more rational delivery model. We live here and the future of this city is our future,” he says. “In the storm, we took all comers and we have been a lifeboat for the medical schools as well. We are doing everything we can to move this community forward and we intend to keep doing it.”—***Howard Larkin*** *is a writer in Oak Park, Ill.*